Referral Submission Form

Please fax the completed form along with patient's insurance card and relevant clinical notes to (844) 889-0275.

Designated Infusion Express center? ____ San Mateo ____ Fremont ____ TBD

Patient Information

Patient Name _____ DOB _____

Address _____ Email _____

City, State, Zip Code _____ Home Phone _____

Enrolled in Funded Program? ____ Yes ____ No ____ N/A Mobile Phone _____

Prescriber Information

Prescriber's Name _____ Practice Group _____

State License # _____ Address _____

NPI #_____ City, State, Zip Code _____

Contact Name _____ Phone _____

Contact Email _____ Fax _____

Insurance Information (Please fax/email insurance card if available)

Primary Payer _____ Group # _____

Subscriber Name _____ ID # _____

Secondary Payer _____ Group # _____

Subscriber Name _____ ID # _____

Diagnosis and Clinical Information

ICD Code _____ Hypersensitivity Treatment:

Description _____ ____ IVX Reaction Policy & Procedure ____ Other (If other, attach with fax)

Continuation Therapy? ____ Yes ____ No Failed Prior Treatments? ____ Yes ____ No

If Yes, PA #? _____ If Yes, Drugs _____

Allergies _____ TB/PPD Status _____ Date _____

Prescription Information

Medication _____ Quantity _____ Route of Administration: ____ IV ____ Injection

Dose/Strength _____ Length/Date Range _____

Induction? ____ Yes ____ No Premeds with Dose _____

Directions _____ _____

_____ _____

Labs (If you would like labs drawn for this patient, indicate below)

Panel: ____ CBC with Diff ____ CBC w/out Diff ____ CMP ____ Hepatic function ____ CRP ____ SED Rate ____ Other _____

Frequency: ____ With Each Dose ____ Every 8-12 Weeks ____ Every 6 Weeks ____ Other _____

Physician Signature Required

x_____ _____ | Patient is interested in patient support programs

Dispense as Written Date

SAN MATEO | 66 Bovet Rd, Suite 105 | San Mateo, CA 94402 | phone: (650) 288-0826 | fax: (844) 889-0275
FREMONT | 43360 Mission Blvd, Suite 100 | Fremont, CA 94539 | phone: (510) 992-4114 | fax: (844) 889-0275